HA-0109-0403p

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

# STATE HEALTH BENEFITS PROGRAM COVERAGE WAIVER/REINSTATEMENT

**Part 1:** To be completed by the employee. Please print.

1. Name _____ SS# _____

Check one box below.

☐ **Waiver of Coverage**
In accordance with Chapter 259, P.L. 1995 (municipalities), Chapter 189, P.L. 2001 (municipal authorities), or Chapter 3, P.L. 2003 (county colleges) I have agreed to waive the State Health Benefits coverage to which I am entitled because I am covered under other health coverage.

Name of other health plan: _____
In place of health benefits, my employer will pay me the amount shown in Part 2 below. I understand that I may resume State Health Benefits Program coverage when I am no longer covered by the other health coverage.

☐ **Reinstatement of Coverage**
I previously waived State Health Benefits coverage since I had other health coverage. As of _____,
*(date)*
I am no longer covered by the other health plan, so I request reinstatement of the State Health Benefits coverage.

**Employee's Signature** _____ **Date** _____

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**Part 2:** To be completed by the employer. Check one box below.

☐ We will pay the above employee $_____ every _____ in place of providing State Health Benefits coverage. We understand that this payment may not be more than 50% of the amount saved by the employer because of the waiver.

☐ We request reinstatement of this employee's State Health Benefits coverage.

**A completed State Health Benefits Application must be attached to either a waiver or a reinstatement.** If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employer Name _____ SHBP Location # _____

Signature of Certifying Officer _____ Date _____